



State of California—Health and Human Services Agency
Department of Health Services



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MEDICAL GUIDELINES

STATE INDIAN HEALTH PROGRAM



MEDICAL GUIDELINES

State Indian Health Program

These guidelines represent the minimal standards for medical service delivery in Indian Health Program (IHP) funded agencies. The grantee is responsible for implementing a quality of services that is consistent with these guidelines. The State Indian Health Program acknowledges that medical standards are ever changing, and that these are minimal standards. They are a part of the system utilized by the IHP in evaluating the medical component of a primary health care program.

Primary health care medical services shall consist of a prevention oriented primary health care program which shall provide for, but shall not be limited to, the following specific components: Comprehensive history and physical examinations; diagnosis, treatment, and follow-up of uncomplicated illnesses and diseases; minor surgery and emergency medical services; prenatal and postpartum services; family planning services; pediatric services consistent with Child Health and Disability Prevention (CHDP) Program; and nutrition services.

I. Licensure and Certification of Medical Service Location

A. Licensure and Certification

All primary care sites shall be licensed, certified, or exempt by the State as primary care clinics and shall be in compliance with all applicable federal, state, and local standards including those for fire and safety. (See California Code of Regulations, Title 22, Chapter 7, Primary Care Clinics.)

II. Policies and Procedures of the Medical Department

- A.** Policies, procedures and protocols shall comprehensively describe the medical program at all service sites.
- B.** Policies and procedures shall be:
 - 1. Current with documented annual review.
 - 2. Available to all medical staff.
 - 3. Adapted to the specific staffing pattern and program practice of the medical department and delineate staff responsibilities.
 - 4. In a consistent format

III. Medical Department Staff

A. Organizational Chart

An organizational chart shall accurately reflect the current lines of authority and supervision of all positions within the medical department.

B. Meetings of the Medical Staff

The medical staff shall meet as a department at least monthly. Meetings shall be documented with minutes.

C. Medical Director

1. A physician shall be designated as medical director and shall be responsible for the overall services, policies, procedures and protocols of the medical department, which include, but are not limited to:
 - a. Establishing, reviewing, updating, and approving all medical policies, procedures, protocols, and standardized procedures at least annually with appropriate documentation.
 - b. Assuring that all medical department staff complies with established policies, procedures, protocols, and standardized procedures.
 - c. Assuring the quality of medical services provided to all clients treated by the grantee.
 - d. Establishing and implementing a system of medical quality assurance/performance improvement (QA/PI), or participating in agency-wide QA/PI.
 - e. Assuring that all medical staff has valid licensure for practice in California and that staff function within the scope of practice permitted by his/her licensure. The licensure shall be without restriction or probationary status.
2. At least one physician on staff shall have admitting privileges at a nearby hospital, or as approved by the Department of Health Services a plan for ensuring needed hospital services.

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D. Nurse Practitioner

1. Nurse practitioners shall function in compliance with the current California Nurse Practice Act.
2. Standardized procedures are in compliance with the current California Nurse Practice Act and with standards established by the Board of Registered Nurses. Standardized procedures clearly state the extent of physician supervision (if any) required and the need for consultation for procedures done by the nurse practitioner.
3. Standardized procedures are dated and signed by the nurse practitioner and medical director within the last 12 months.
4. Physician consultation for nurse practitioners is available by telephone if physician is not on-site.

E. Registered Nurse

Every medical clinic shall employ a registered nurse. Responsibilities of the registered nurse shall include but not be limited to:

1. Developing and reviewing all clinic nursing policies, procedures and services of the contractor.
2. Assuring that all nursing decisions and activities are rendered by qualified nursing personnel.
3. Assuring that nursing care meets the standards of acceptable nursing practice.
4. Assuring that all necessary standardized procedures are in compliance with the California Nursing Practice Act and standards established by the California Board of Registered Nursing.
5. Providing supervision, coordination of activities and in-service education to appropriate clinic staff.
6. Acting as liaison between the grantee and other community agencies.

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F. Physician Assistant

1. Physician Assistant scope of practice/delegation of services agreement shall:
 - a. Be dated and signed by physician assistant, medical director, and clinic administrator within the last 12 months.
 - b. Indicate the scope of practice for this physician assistant in this practice and comply with Physician Assistant Laws and Regulations issued by Physician Assistant Committee.
 - c. Be developed with a physician supervisor before a physician assistant may provide service.
2. Physician Assistant protocols shall:
 - a. Be dated and signed by physician supervisor and medical director within the last 12 months.
 - b. Reflect requirements in the Laws and Regulations Relating to the Practice of Physician Assistants.
3. Medical review and supervision of physician assistant.
 - a. Physician supervisor reviews, dates, and signs all or a designated percentage of physician assistant records.

G. Staff Training

1. Training plans for medical department employees should be developed annually and shall reflect program and staff development needs.
2. Full-time licensed staff shall be allowed paid time off sufficient to maintain licensure.
3. All Medical staff shall sign a confidentiality statement annually.

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H. Position Descriptions

1. Current position descriptions shall be available for all positions within the medical department.
2. Position descriptions shall delineate responsibilities, supervisory relationships and minimal qualifications for the position.

I. Performance evaluations

1. All medical staff shall be evaluated regarding performance during a described probationary period and at least annually thereafter.
2. Performance evaluations shall be based on job specific criteria, shall be signed by the employee and the supervisor, and shall be filed in the employee's personnel file.

IV. Medical Services

A. Scope of Services

The grantee shall provide or arrange for the provision of the full range of medical services.

B. Visit Planning

Daily appointment time shall be allocated for each provider to review records and plan services for scheduled patients.

C. Patient Triage

1. Current triage protocols are available for staff use.
2. All clients needing immediate attention are referred to a registered nurse or medical provider for triage.

D. Follow-up of Missed Appointments.

A registered nurse or medical provider shall review missed appointments for required follow-up. This review shall be documented.

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E. Mandated Screening and Reporting

1. The medical department shall have written procedures for implementing all mandated screening and reporting, including but not limited to:
 - a. Reportable diseases or conditions as identified in Title 17, Chapter 4, Article 1, Section 2500 California Code of Regulations.
 - b. Suspected or confirmed cases of pesticide exposure or illness.
 - c. Suspected or confirmed child/dependent adult abuse.
 - d. Screening for domestic violence
 - e. Suspected or confirmed domestic violence.
2. Procedures for each mandated report shall include:
 - a. The name, address and telephone number of the agency to whom the grantee reports.
 - b. The specific reporting form or electronic procedure, available at the service site.
 - c. Specific staff responsibilities.

F. Twenty-four Hour Medical Coverage

The medical department shall be responsible for providing medical coverage to patients at all times, including after-hours coverage. Information for patients seeking medical care after the clinic is closed shall be clearly indicated (posted on front door, on nearby sign, etc.)

g. Traditional Indian Health

The medical department shall have a policy in place that recognizes Traditional Indian health practices and describes the manner in which clinic staff shall respond to client requests for such services. Staff orientation shall address Traditional Indian health policy.

V. Emergency Services

A. Emergency Supplies:

1. The emergency kit shall be accessible and portable, with a list of contents on the outside of the kit, and with documentation of monthly review of contents and oxygen equipment.
2. At a minimum, the emergency kit shall contain:
 - a. Oxygen
 - b. Suction
 - c. Ambu bag with pediatric and adult mask
 - d. Pocket mask
 - e. Airways and laryngoscope (adult and pediatric)
 - f. Sterile intravenous system
 - g. Tourniquet
 - h. Flashlight
 - i. Stethoscope and sphygmomanometer
 - j. Basic emergency pharmaceuticals

B. Emergency Telephone Numbers

Emergency telephone numbers shall be posted on each telephone in the medical department and shall include:

1. 911, or ambulance service, police, and fire department
2. Nearest hospital available for emergency medical services.
3. The nearest poison control center.

C. Emergency Medical Procedures

1. Procedures addressing on-site medical emergencies shall be in place
2. A medical emergency drill shall be conducted and documented at least annually.
3. All licensed/certified medical staff shall maintain current certification in cardiopulmonary resuscitation.

VI. Clinical Records and Health Information

State IHP acknowledges the use of and information contained in the RPMS record system. The following standards are based on Federal Indian Health Service (IHS) and other acceptable community standards. A comprehensive medical record based on the RPMS system is capable of demonstrating the following informational database.

A. Individual client health records.

There shall be a health record for each client who receives care from the medical department.

B. Policies and Procedures for Health Records

1. Policy and procedures shall comprehensively describe the medical record (paper or electronic) system. This system shall be in compliance with all applicable state and federal laws and shall address the security, confidentiality and access privileges of the system
2. Policy shall address purging old documents and inactive records.
3. Policy shall address the organizational system of each clients record

C. Consents

1. Policy and procedure shall clearly describe circumstances requiring written consent. These procedures shall include:
 - a. The staff responsible for obtaining the consent.
 - b. Procedures for obtaining specific consents.
 - c. Approved consent forms.
 - d. The filing of consents in the health record.
2. Consent procedures shall be in place for at least the following:
 - a. General treatment
 - b. Treatment of minors
 - c. Release of information
 - d. Family Planning

D. Problem Oriented Health Records

Medical records shall be maintained in a manner consistent with the problem oriented health record format. This shall include but not be limited to problem lists, medication lists, and progress notes organized in SOAP (subjective, objective, assessment, plan) or other recognized format.

E. Pediatric Records

1. Basic information in the record which is updated periodically shall include full name of child, surname of parent if different, gender, address, home or message telephone, date of birth, ethnicity and eligibility; name, relationship to patient, and telephone number of emergency contact; and method of payment.
2. Signed consents for general treatment shall be a part of the record. Any person giving consent for the treatment of a minor shall indicate relationship to minor.

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3. Health history and physical examinations shall:
 - a. Be consistent both in frequency and content with the Child Health and Disability Prevention (CHDP) Program Periodicity requirements;
 - b. Address at least: height, weight, developmental milestones, ears, throat, mouth, teeth, gums, neck, chest, heart, spine, abdomen, genitals, extremities, femoral and brachial (or radial) pulses, and head circumference;
 - c. Include screening tests for vision and hearing, hematocrit/hemoglobin, urinalysis, blood lead, tuberculosis skin testing and other tests per current CHDP Periodicity Table.
4. Medication and other allergies shall be noted in the health record.
5. Current immunization status shall be documented in the health record.
6. Pediatric growth charts shall be current.
7. Health education/anticipatory guidance addresses age appropriate topics e.g. safety and injury prevention, nutrition, dental hygiene/exams, tobacco, drugs, and alcohol.
8. Problem Lists
 - a. A current problem list shall be in place in each health record.
 - b. All chronic problems shall be listed and acute problems may be listed.
 - c. All problems noted shall include the start/stop dates.
9. Medication Lists
 - a. A current medication list shall be in place in each health record.
 - b. All chronic medications shall be listed and acute medications may be listed.
 - c. All medications noted on the medication list shall include the dosage and the start/stop dates.

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10. Each progress note shall include:

- a. Date of visit, signature and title of the person making the notation.
- b. A follow-up plan including return appointment interval.

F. Adult Records

1. Basic information in the record which is updated periodically shall include full name of patient, gender, address, home or message telephone, date of birth, ethnicity, eligibility, usual occupation; name, relationship to patient, and telephone number of emergency contact; and method of payment.

2. Consents

A general treatment consent shall be signed by client and dated.

3. Health History

A health history shall be documented and updated on each client receiving health services.

4. Physical Examinations

Comprehensive physical examinations shall be documented to include at least: interval history, weight, blood pressure, skin, head, eyes, ears, nose, throat, heart and lungs, abdomen, neurological system, extremities, peripheral pulses and genital/rectal exam when appropriate.

5. Health Maintenance

Health maintenance for all adult patients shall be documented in the health record and shall include at least breast exam, self-exam teaching, mammography, Pap smear, rectal exam and PSA as appropriate and PPD as per protocol.

6. Immunizations

Current immunization status as recommended by American Council on Immunization Practices (ACIP) shall be documented in the health record.

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7. Laboratory Tests and X-rays

- a. Orders for all laboratory screening tests and X-rays shall be documented in the health record.
- b. Results of all laboratory screening tests, X-rays, and correspondence/consultation shall be reviewed and initialed by the appropriate health provider.

8. Problem Lists

- a. A current problem list shall be in place in each health record.
- b. All chronic problems shall be listed and acute problems may be listed.
- c. All problems noted shall include the start/stop dates.

9. Medication Lists

- a. A current medication list shall be in place in each health record.
- b. All chronic medications shall be listed and acute medications may be listed.
- c. All medications noted on the medication list shall include the dosage and the start/stop dates.

10. Each progress note shall include:

- a. Date of visit, signature and title of the person making the notation
- b. A follow-up plan including return appointment interval.

G. Flow Sheets

- 1. Flow sheets shall be developed to monitor diabetes and hypertension.
- 2. Flow sheets shall document indices to be monitored and frequency of monitoring.

H. Health Records of Clients Diagnosed with Hypertension.

1. The health records of clients diagnosed with hypertension shall reflect the provision of services consistent with current treatment standards for such clients.
2. The health record shall include the following information for each provider visit.
 - a. Pulse
 - b. Blood pressure
 - c. Follow-up plan including return appointment interval
3. Physical examinations shall be performed at least annually and include:
 - a. Interval health history
 - b. Height (once in adulthood)
 - c. Weight
 - d. Heart
 - e. Lungs
 - f. Fundoscopic exam or documentation of ophthalmologic/optometric exam or referral.
 - g. Peripheral pulses
 - h. Abdomen
 - i. Extremities
4. Laboratory tests will include blood chemistry (potassium, creatinine, cholesterol, glucose, triglycerides) and urinalysis (blood, glucose, protein)
5. Clients over 35 years old shall have an initial EKG and one at least every 3-5 years thereafter.
6. The health record shall document that health education/nutrition counseling regarding hypertension is discussed at least every 12 months.

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7. Current immunization status as recommended by ACIP shall be documented in health record.
- I. Health Records of Clients Diagnosed with Diabetes.
 1. The health records shall reflect the provision of services consistent with Federal IHS and other acceptable community standards.
 2. The health records shall include the following information for each provider visit by a diabetic client:
 - a. Pulse
 - b. Blood pressure
 - c. Foot examination (done at least monthly)
 - d. Follow-up plan including return appointment interval
 3. Physical examinations of diabetics controlled by medication shall be performed at least annually and shall include:
 - a. Interval health history
 - b. Height (once in adulthood)
 - c. Weight
 - d. Heart
 - e. Lungs
 - f. Abdomen
 - g. Peripheral Pulses
 - h. Extremities
- J. Referral to dental clinic or documentation of regular dental care.
- K. Referral to ophthalmologist or optometrist for dilated fundoscopic exam within last 12 months (if at least 3 years since diagnosis).

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- L. Laboratory tests will include blood chemistry (potassium, creatinine, cholesterol, glucose, triglycerides), glycohemoglobin, and urine (blood, glucose, protein)
- M. Clients over age 35 shall have an initial EKG and one at least every 3-5 years thereafter
- N. The health record shall document that diabetes health education/nutrition counseling is discussed at least every 12 months.
- O. Current immunization status as recommended by ACIP shall be documented in the health record.

VII. Quality Assurance/Performance Improvement (QA/PI) Program

- A. A QA/PI program systematically monitors and evaluates the quality of services and service care delivery, seeking to improve that quality to the fullest extent possible.
- B. The medical director shall develop and implement a medical QA/PI program, or shall participate in agency-wide QA/PI.
- C. QA/PI program
 - 1. Medical staff attends documented department-specific or agency-wide QA/PI meetings that are held at least quarterly.
 - 2. Meetings document a process that at a minimum:
 - Identifies problems that are critical to quality of care.
 - Develops a corrective action plan
 - Monitors the corrective action plan
 - Evaluates the results of the corrective action plan.
 - 3. QA/PI addresses key agency-wide and/or department-specific issues, which may include but are not limited to:
 - a. Preventive service specific indicators (e.g., pap smear, mammogram, and immunization rates, sealant and fluoride use).
 - b. Access indicators (e.g. patient flow, waiting time, patient satisfaction).

- c. Measurable health outcome indicators (e.g. blood pressure, compliance with medication, diabetic control, baby bottle tooth decay rates).
- d. Peer review

VIII. Infection Control/Waste Management

- A. Policy and procedure manual shall delineate hazardous medical waste disposal in accordance with the Medical Waste Management Act.
 - 1. Hazardous medical waste is separated from other trash and the receptacle is lined with a red biohazard bag.
 - 2. Hazardous medical waste is stored in a locked area with a tightly fitting lid and a warning sign is posted which is visible for 25 feet.
 - 3. Contaminated laundry is bagged and containerized with lid.
- B. Clinic policies and procedures shall adhere to all state and local regulations related to infection control including, but not limited to:
 - 1. Appropriate onsite management of clients suspected of having communicable disease.
 - 2. Management of communicable diseases occurring within the target Indian community.
 - 3. Use of engineered sharps protection; disposal of sharps in puncture proof containers.
 - 4. Annual training for all personnel regarding infection control, universal precautions, and bloodborne pathogens.
 - 5. Bloodborne Pathogen Exposure Control Plan that is in compliance with Cal-OSHA standards.
 - 6. Immunization against Hepatitis B, or the opportunity to indicate refusal.
 - 7. Monitoring of the autoclave with biological indicators and documentation of results at least monthly

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8. Assurance of integrity of sterilized instrument packages.
9. Posting and proper implementation of infection control guidelines/universal precautions.

IX. Referrals and Linkages

A. Referrals

1. The referral procedures shall be clearly defined in policy and procedure.
2. All referrals to and from the medical department shall be written and tracked.
3. Referral agreements shall include: Agency contact person(s), provision for sending and receiving of patient records and written reports, and financial responsibilities.
4. All referrals for off-site health services shall be reviewed by a clinic physician either at the time of the referral or at a subsequent case review.

B. Linkages

1. Efforts to establish written agreements with agencies or individuals providing obstetrical and emergency services to clients shall be documented.
2. The medical department shall collaborate with the CHS department to develop and implement community health activities.

X. Pharmacy Services

A. Staff Responsibilities

1. An appropriate medical staff person shall be responsible for reviewing and ordering all drugs available in the medical department.
4. Distribution of all medication shall be done in accordance with in accordance with all applicable laws and regulations.
3. No drug or treatment shall be given except on the signed order of a person legally authorized to give such an order.

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B. Dispensing

1. When dispensed by the medical department, prescribed drugs shall be provided to patients in accordance with all applicable laws and regulations.
2. Labels of drugs dispensed by the medical department shall conform to all applicable laws and regulations. Labels shall include: Name and address of furnisher (clinic), patient's name, provider, date of issue, drug name, manufacturer if generic, strength of drug, quantity, directions for use and expiration date

C. Documentation

1. Medications and treatment orders shall be promptly entered in the patient's health record. When medication is administered onsite, the health record shall reflect: medication, dosage, time and route of administration, and name and professional credentials of person administering the medication.
2. A formulary shall be available for all prescription medications dispensed or covered by third party payer.

D. Controlled Drugs

1. Controlled drugs shall be locked at all times and accessible only to licensed providers.
2. Controlled drugs shall be inventoried and maintained consistent with applicable state and federal laws.

E. Pharmaceutical Storage

Pharmaceuticals, including immunizations, shall be stored in a secure area with appropriate temperature controls. No outdated or deteriorated drugs shall be available for use.

XI. Clinical Equipment and Supplies

A. Equipment Maintenance

1. All equipment in the medical department shall be cleaned, calibrated and/or serviced appropriately according to manufacturer's recommendations.

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2. All such equipment shall be identified on an equipment maintenance schedule, which shall include staff responsibilities and frequency of maintenance.

XII. Laboratory Services

- A. All laboratory tests performed will be in compliance with Clinical Laboratory Improvement Amendment (CLIA) 1988. Agencies must have a current and valid CLIA certificate.
- B. Qualified personnel shall perform appropriate lab tests per CLIA guidelines.

XIII. Workplace / Environment/Safety

- A. Environment is maintained to provide for physical safety of patients, visitors, and staff with no obvious safety hazards
- B. Facility is clean and sanitary.
- C. Hand washing facilities are accessible in all treatment areas.
- D. Bathrooms are equipped with soap and towels, and a hand washing sign is visible.
- E. Exit signs are visible (and optionally lit); legible emergency evacuation map is posted.
- F. Disability accommodations include a wheelchair ramp, water fountain at wheelchair height, elevator (if applicable), designated parking, and accessible bathroom facilities.